STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	155171	B. WING		06/05/2012	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN MEADOWS		/ JEFFERSON ST (LIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FUI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	ON) TAG	DEFICIENCY)	DATE	
F0000					
	This visit was for the Investigation of	F0000	The creation and submission	of	
	This visit was for the Investigation of	10000	this Plan of Correction does n		
	Complaint IN00108355.		constitute an admission by thi		
	Complaint IN00108355 substantiated,		provider of any conclusion set	t	
	federal/state deficiencies related to the		forth in the statement of deficiencies, or of any violatio	n of	
			regulation. This provider		
	allegations are cited at F312 and F441.		respectfully requests that the		
	Survey dates: June 4 & 5, 2012		of Correction be considered the Letter of Credible Allegation of	I	
			after 6/18/2012.		
	Facility number: 000087				
	Provider number: 155171				
	AIM number: 100289890				
	Survey team:				
	Joyce Hofmann, RN, TL				
	Barbara Hughes, RN				
	Census bed type:				
	SNF/NF: 97				
	Total: 97				
	Census payor type:				
	Medicare: 6				
	Medicaid: 80				
	Other: 11				
	Total: 97				
	Sample: 5				
	These deficiencies also reflect state				
	findings in accordance with 410 IAC				
	16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DAT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		B. WING	00	(X3) DATE S COMPLI 06/05/2	ETED			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT	FRANKLIN MEADOWS	EADOWS	1285 W JEFFERSON ST						
Overlitz marriagy commutated 6/9/12	PREFIX (EACH DEFIC	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI	D BE	(X5) COMPLETION DATE			
Quanty review completed 6/8/12 Cathy Emswiller RN		thy Emswiller RN							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155171	B. WIN			06/05/	2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				/ JEFFERSON ST		
FRANKL	IN MEADOWS				(LIN, IN 46131		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES	1	ID	· I		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE
F0312	483.25(a)(3)			1110			
SS=E	ADL CARE PRO RESIDENTS	VIDED FOR DEPENDENT					
	A resident who is unable to carry out activities of daily living receives the necessary services						
	to maintain good personal and ora	nutrition, grooming, and Il hygiene.					
	Based on observa	ation, interview, and	F03	12	F312 ADL CARE PROVIDED FOR		06/18/2012
	record review, th	e facility failed to ensure			DEPENDENT RESIDENTS		
	staff performed p	peri care properly, staff			It is the practice of this provider to		
	performed prope	r hand washing			ensure a resident who is unable to		
		staff handled soiled			carry out activities of daily living		
	• •	o prevent potential			receives the necessary services to maintain good nutrition, grooming,		
		of 5 residents reviewed			and personal and oral hygiene.		
					What corrective action(s)		
		laily living in a sample of			will be accomplished for		
	-	Resident #C, and			those residents found		
	Resident #D]				to have been affected by		
					the deficient practice		
	Findings include	:					
					RN #1, LPN #2, CNA #1, CNA #2, and		
	Interview with L	PN #1 on 06/04/12 at			CNA #3 have been re-educated on		
	11:50 a.m. indica	ated incontinence checks			proper perineal care, proper hand	_	
	for residents wer	e done every 2 hours for			washing techniques, and handling o	f	
		e and residents on a			soiled linen properly to prevent potential infections.		
	•	n were also toileted every			potential infections.		
		indicated staff just do			How other residents		
		to get everybody taken			having the potential to be		
	care of during the	• • •			affected by the same		
	care or during the	at time period.			deficient practice will be		
	Internia 141 B	NI #1 06/04/12 2			identified and what		
		N #1 on 06/04/12 at 2			corrective action(s) will		
	-	ere were five residents			be taken		
	with open areas of	•					
		e resident's open areas			Dependent residents that reside in		
	•	ise. RN #1 indicated			this facility have the potential to be		
	Resident #A had	an open area on right			affected by the alleged deficient practice. Licensed nurses and		
					practice. Licensed flurses and		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII I	A. BUILDING 00			ETED
		155171	B. WING			06/05/2	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			JEFFERSON ST		
FRANKL	IN MEADOWS				LIN, IN 46131		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		1	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE .	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	buttock, stage II	, and was incontinent and			certified nursing assistants have		
	Resident #C had	an open area on her			been re-educated by the		
	coccyx, stage II. The other two resident				DNS/Designee in proper perineal		
	1 -	aused by a brace and a			care, hand washing technique, and		
	_	eter. One resident			proper infection control techniques		
		e week-end had a stage			related to handling soiled linen by June 18, 2012. Licensed nurses and		
	IV when admitte	· ·			certified nursing assistants have		
	I V WHEH admitte	cu.			completed a skills validation. The		
	1) 5 11				DNS/Designee in-serviced all nursin	g	
	/	A was observed for			staff that included hand washing,		
		e on 06/04/12 at 3:40			perineal care, handling of soiled		
	^	ound nurse, RN #1,			linen, and infection control. A		
	performing the o	are. RN #1 was observed			post-test was administered to		
	to fill the basin v	with water, let the resident			ensure understanding of in-service		
	test for warmth t	imes 2, got her gloves,			provided. Newly hired certified		
	and turned on th	e light. RN #1 was			nursing assistants complete a		
	observed to don	gloves, washed the front			peri-care and hand washing skills		
		with soap, rinsed the			validation. The validations are then completed no less than annually		
	^	l placed the soiled cloths			thereafter. DNS/Designee to		
	· ·	ped table. RN #1			monitor.		
		dried the front peri-area,					
		d towel on the resident's					
		foot of the bed. RN #1			What measures will be		
	-	and applied a cream on			put into place or what		
		ner upper thigh areas			systemic changes will be made to ensure that the		
		were observed to be red			deficient practice does		
	1				not recur		
		om the groin area and					
		thighs almost to her			Licensed nurses and certified nursir	ng	
		nanged her gloves, got a			assistants have been re-educated b	у	
		pagged the soiled linens,			the DNS/designee in proper perinea	al	
	left the room without washing her hands, and returned with clean linens.				care, hand washing technique, and		
					proper infection control techniques		
					related to handling soiled linen by		
		during interview at this			June 18, 2012. All licensed nurses and certified nursing assistants have	_	
	time, that the res	sident was incontinent of			and certified fluiding addictable flavo		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	ETED
		155171	B. WIN			06/05/2	2012
NAME OF A			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER	C		1285 W	/ JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		soaked through her pad			completed a skills validation. The		
	and sheet onto the	ne mattress. RN #1 took			DNS/Designee in-serviced all nursing	g	
	the basin of water	er and changed the water.			staff that included hand washing,		
					perineal care, handling of soiled linen, and infection control. A		
	CNA #1 came in	to the room to assist RN			post-test was administered to		
	#1 with the resid	ent's incontinence and			ensure understanding of in-service		
	bed change. RN	#1 and CNA #1 were			provided. Licensed nurses will utilize	e	
	_	gloves without first			the nurse rounds checklist to		
		ds. RN #1 washed the			monitor nursing staff on all shifts 7		
		ttock, placed the soiled			days a week x 2 weeks to ensure		
		r-the-bed table instead of			appropriate ADL care is provided.		
					DNS/Designee will monitor for		
	-	anged gloves, rinsed the			compliance. Newly hired certified		
	· ·	hed the mattress with the			nursing assistants complete a peri-care and hand washing skills		
	-	ed the soiled cloth on the			validation. The validations are then		
		le, then dried the resident			completed no less than annually		
	and mattress and	l placed the soiled towel			thereafter.		
	on the bedspread	at the foot of the bed.					
	RN #1 changed	gloves and made her side					
	of the bed, then	the staff rolled the			How the corrective		
	resident to her ri	ght side and CNA #1			action(s) will be		
	removed the soil	ed pad and sheet, placed			monitored to ensure the		
	them in a plastic	bag, and made her side			deficient		
	_	x #1 changed gloves,			practice will not recur, i.e., what quality		
		buttock, rinsed, and			assurance program will		
	_	t. Both staff changed			be put into place; and by		
		oplied the cream again to			what date the systemic		
		nt peri-area, and CNA #1			changes will be completed		
		-					
		n to the back peri-area.			Nurse managers will comple	ete	
	_	d gloves, RN #1 left one			the nurse rounds check off		
	glove on and put the soiled towel and cloths in the bag with the other soiled linens. CNA #1 left the room with the				tool 3 times a week for 4		
					weeks and then weekly		
					thereafter until compliance		
	_	ens, and failed to wash			has been met for two		
	her hands prior t	o leaving the resident's			consecutive quarters. The (וטכ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155171	B. WIN	IG		06/05/	2012
NAME OF I	DD OVIDED OD GUDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	PROVIDER OR SUPPLIEF	· ·		1285 W	JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 46131		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nptied, rinsed, and dried			committee will review the to	ools	
	the basin, and washed her hands prior to				monthly. If at any time the		
	leaving the resid	ent's room. There was no			threshold falls below 95%, a	an	
	hand washing do	one between the washing			action plan will be initiated.		
	of the front perir	neal area and the back					
	buttocks.						
	During the incor	ntinence care, the resident					
	_	have a red inflamed rash					
		a and down both inner					
	_	est to her knees. RN #1					
	_	interview at this time,					
	_	diarrhea over the					
		caused it to be red. RN					
		area on the right buttock					
		have a slightly raised area					
		length and less than 1/2					
		he area was observed to					
	be closed at this	time.					
	Review of the re	esident's clinical record on					
	06/04/12 at 2:45	p.m. lacked					
		of the resident having					
	diarrhea over the						
	Review of week	ly skin documentation					
		through 05/14/12					
		en areas on Resident #A.					
	_	documentation dated					
	1	ed open areas on the					
		1					
	buttocks. The clinical record indicated						
	the open was found on 05/11/12 and						
	measured 2.0 x (
	[centimeters]. T	he area was red and the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155171	A. BUIL	DING	00	COMPL 06/05/	
		155171	B. WINC			06/05/	2012
NAME OF I	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP CODE		
EDANIZI					JEFFERSON ST		
FRANKL	IN MEADOWS			FRANKI	LIN, IN 46131		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	treatment was du	ioderm.					
	resident was in a 05/13/12 for an u [UTI] and was st mg. [milligrams] hours times 14 d. The resident's ca indicated a problimpaired skin into the resident shall buttock problem included low air loss matted needed, and treated. The resident's ca indicated a problem included, but we with incontinent incontinence ever juice per order.	inical record indicated the and out of the hospital on arinary track infection tarted on Macrobid 100 by mouth every 12 ays. The plan dated 05/15/12 bem of "Resident has tegrity: stage 2 Location: The proaches to the digital dated to, are seen incontinent care as tement as ordered. The plan dated 12/08/11 bem of "Resident is at risk att, UTERINE TRACT DN." Approaches re not limited to, assist care as needed, check for ary 2 hours, cranberry					
		Potential for skin					
		ed to: impaired mobility,					
	1	eds assist with transfers					
	and bed mobility, occasionally slides						
	down in bed, edema to bilateral lower						
		ous insufficiency, hx					
	stasis ulcers." A	pproaches included, but					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/05/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	were not limited every two hours. incontinent episod barrier, assist resperi care after ea and use transfer/staff to pull up in 2). Resident #D incontinence care a.m. with CNA # performing the chands prior to pe #3 was observed prior to care. Both CNA #2 washed wet cloth. The addry the resident's aides turned the and CNA #2 was buttock's area. The sacral area was made to the flown. The resident with the same so placed a clean goth gotten out of the top of the resident was a continuous placed.	to, check and change Pericare after ode and apply skin ident with toileting and ch incontinent episode, incontinent pad and 2 in bed. O was observed for e on 06/05/12 at 10:55		TAG	DEFICIENCY)		DATE	
		CNA #3 removed her aides washed their hands						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155171	B. WIN			06/05/2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
					JEFFERSON ST	
FRANKL	IN MEADOWS			FRANKI	LIN, IN 46131	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE	DATE
	•	ng the resident's room.				
	CNA #2 failed to wash her hands and change gloves between washing the front					
		_				
	-	the washing the back				
		and feces on it. CNA #2				
		er hands after providing				
		e of both urine and feces				
		ing a clean gown on the				
		3 failed to remove her				
	1 -	her hands prior to getting				
	a clean gown out	the resident's closet.				
	D					
		ent #D's clinical record				
		1:`15 a.m. indicated the				
	·	noses which included,				
		ited to, cerebral palsy,				
	•	etual disability, severe				
		ility, dysphagia, aphasia,				
	contractures, and	l megacolon.				
		sident's skin evaluation				
	_	14/12 indicated the				
		w area, stage II, which				
		.0 x < 0.1 cm. on the top				
		Another skin evaluation				
	_	5/12 indicated a new				
	_	nich measured 0.6 x 0.5 x				
		left bottom buttock.				
	_	ock closed by 05/25/12				
		m buttock closed on				
	05/30/12.					
		ne Director of Nursing				
	[DON] on 06/05	/12 at 2:15 p.m. indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155171				LDING	NSTRUCTION 00	(X3) DATE COMPI 06/05	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE	
TAG	both area on Res were healed. The the duoderm on the which was seen of incontinence care she did not know did not return with the state of the property of the labia with legalized folds or above the changed gloves a resident to her right the area of the property of the	ident #D's left buttock e DON was asked what he sacral area was for on observation during e. The DON responded r, but would find out, but		TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE	
	LPN #2 bunched changing the line turn the resident cleaning of the b the resident to he	was lying in the urine. the sheet and pad for ens, however she did not to the other side for uttock. LPN #2 did turn er for changing the linens, were changed, the LPN						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155171	B. WIN			06/05/2	2012
NAME OF F	PROVIDER OR SUPPLIEF	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ne mattress of any urine					
		changing the sheets a					
	1 ^	as removed from the					
		d that the LPN identified					
	as a t-shirt.						
	D 11						
		inical record was					
		04/12 at 2:30 p.m. and					
		ident was a stroke patient					
		do anything for herself					
		not use her hands. During					
		Lesident #C on 06/05/12 at					
	· ·	at #C showed how her					
		racted and commented					
		f their use. Resident #C					
		interview at this time,					
		her buttocks hurt like					
	lighting a match	to it.					
	Review of the fa	cility's most recent					
		olicy dated 03/2012,					
	•	NA Skills Validation					
	sheet, indicated						
		s: 1. Verify resident and					
	_	re. 2. Provide for					
		sh hands. 4. Put on					
	1 *	st resident to supine					
	_	ape resident to supme					
	_	with warm water and have					
		emperature. 8. Assist					
		•					
	resident to spread legs and lift knees if possible. 9. Wet and soap folded wash						
	_	E: If resident has					
	catneter, check f	for leakage, secretions or					

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Facility ID: 000087

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PRINTED: 06/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155171				LDING	NSTRUCTION 00	(X3) DATE COMPL 06/05/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	meatus downwar inches. Do not rused wash cloth. Cloth. Wet, soap Females: 12. Se urethral area first outside labia in dalternate from si front to back and outward. 15. Us wash cloth with rewipe area, unlet the wash cloth. Oneeded. Males: basin. With a clearea, thoroughly when washing. 2 same direction as Assist resident to 23. Wet and soa anal area from frarea of wash cloth not rewipe area, of the wash cloth needed. 25. Chawith a clean was thoroughly in the washing. 26. Go direction was white resident to run or	wipe catheter from d for approximately four ewipe catheter. Discard 11. Obtain clean wash and fold wash cloth. Sparate labia and wash it. 13. Wash between and downward strokes. 14. de to side - wipe from from center of perineum is a clean area of the each wipe. Do not ess using a clean area of Change wash cloth as 20. Change water in ean wash cloth, rinse in the same direction as 21. Gently pat area dry in its when washing. 22. To turn onto side away. It is possible to back, using a clean area of the change wash cloth. 24. Clean ont to back, using a clean area of the change wash cloth as using a clean area of the change wash cloth as the cloth, rinse area, as same direction as when ently pat area dry in same en washing. 27. Assist into back and undrape move gloves. 29. Wash						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
ANDILAN	or conduction	155171		LDING		06/05/	
		166171	B. WIN		A DDDDGG GUTU GTATE TID GODE	00/00/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST		
FRANKL	IN MEADOWS				LIN, IN 46131		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DIA TELENCT)		DATE
	Review of the fa						
	1	with reviewed date of					
	· · · · · · · · · · · · · · · · · · ·	ed, "POLICY: The ll handle, store, process,					
		en appropriately to					
	_	ad of infection, in					
	1 ^ ^	as and in the laundry					
		SE: To ensure the					
		nen and laundry to					
	1 ^ ^	nd of infection Place					
	soiled linen in pl						
	Solice illien ill pi	ustic oug					
	Review of the fa	cility's policy for Hand					
		was also a CNA Skills					
	' '	list, dated 03/2012,					
		Moment of required hand					
		ore patient * Before an					
	' '	fter body fluid exposure					
		ient contact * After					
	_	ent surroundings."					
	Î	ū					
	Interview with th	ne Administrator on					
	06/05/12 at 2:50	p.m. indicated the					
	facility does not	have any other policies					
	_	n what was already					
	1 ^	e realized what was					
	provided was a to	•					
		did not contain the					
	detailed information	tion about pericare, and					
	that they need to	work on that.					
	_	relates to Complaint					
	IN00108355.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUILDING B. WING	00	COMPLETED 06/05/2012				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
FRANKLI	N MEADOWS			JEFFERSON ST LIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-38(a)(3)	,						

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Event ID: UJ7C11

Facility ID: 000087

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
	155171		B. WIN			06/05/	2012	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	8						
ED ANIZI I	NIMEADOMO				JEFFERSON ST			
FRANKLI	N MEADOWS			FRANK	LIN, IN 46131			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE .	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE	
F0441	483.65							
SS=E	INFECTION CO	NTROL, PREVENT						
	SPREAD, LINEN							
		establish and maintain an						
	•	Program designed to						
		anitary and comfortable						
	•	I to help prevent the						
		d transmission of disease						
	and infection.	a transmission of alocado						
	and inicotion.							
	(a) Infection Con	atrol Program						
		establish an Infection						
	Control Program							
		controls, and prevents						
	infections in the							
		t procedures, such as						
	, ,	be applied to an individual						
	resident; and	be applied to all illulvidual						
	•	ecord of incidents and						
	• •	s related to infections.						
	corrective action	3 related to infections.						
	(h) Preventing S	pread of Infection						
		ection Control Program						
	, ,	a resident needs isolation to						
		ad of infection, the facility						
	must isolate the							
		nust prohibit employees with a						
	· '	isease or infected skin						
		ect contact with residents or						
		ct contact will transmit the						
	disease.	ct contact will transmit the						
		nust require staff to wash their						
		n direct resident contact for						
		hing is indicated by accepted						
	professional pra							
	professional prac	ouoc.						
	(c) Linens							
		handle, store, process and						
		so as to prevent the spread						
	of infection.	so as to prevent the spread						
		,	F04	<i>1</i> 1			06/18/2012	
		ation, interview, and	104	41	F441 INFECTION CONTROL,		00/18/2012	
	record review, th	ne facility failed to ensure						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLET			ETED		
		155171	B. WIN			06/05/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			JEFFERSON ST		
EBANKI	IN MEADOWS				LIN, IN 46131		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	staff washed the	ir hands after each direct			PREVENT SPREAD, LINENS		
	resident contact	for which hand washing					
	is indicated by a	ccepted professional			It is the practice of this provider to		
	practice for 4 of	7 staff observed for			ensure the facility establishes and		
	1 *	he facility failed to			maintains an Infection Control		
		lled soiled linens as to			Program designed to provide a safe,	,	
					sanitary and comfortable		
		ad of infection for 3 of 7			environment and to help prevent		
		or linen handling. [RN #1,			the development and transmission		
	CNA # 1, CNA #	#2, and CNA #3]			of disease and infection.		
					What corrective action(s)		
	Findings include	:			will be accomplished for		
					those residents found		
	1). Resident #A	was observed for			to have been affected by		
	,	e on 06/04/12 at 3:40			the deficient practice		
		ound nurse, RN #1,			the deficient practice		
	_				RN #1, CNA #1, CNA #2, and CNA #3		
	1	are. RN #1 was observed			have been re-educated on the	'	
		with water, let the resident			practice of washing their hands afte	r	
		imes 2, got her gloves,			each direct resident contact along		
	and turned on the	e light. RN #1 was			with the policy and procedure of		
	observed to don	gloves, washed the front			handling soiled linens to prevent the	e	
	peri-area times 2	with soap, rinsed the			spread of infection.		
	_	l placed the soiled cloths					
		ped table. RN #1			How other residents		
		dried the front peri-area,			having the potential to be		
		-			affected by the same		
	-	d towel on the resident's			deficient practice will be		
	_	foot of the bed. RN #1			identified and what		
		and applied a cream on			corrective action(s) will		
	the resident's inn	er upper thigh areas			be taken		
	bilaterally. RN #	#1 changed her gloves,					
	got a plastic bag	and bagged the soiled			Residents that reside in this facility		
		oom and returned with			have the potential to be affected by	,	
	· ·	I #1 indicated the resident			the alleged deficient practice.		
		of urine and it had soaked			Licensed nurses and certified nursin	g	
					assistants have completed a skills		
	unrougn ner pad	and sheet onto the			validation. The DNS/Designee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
155171		B. WIN			06/05/2	2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 46131		
(X4) ID	STIMMADV S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		took the basin of water			in-serviced all nursing staff that		
					included hand washing, perineal		
	and changed the	water.			care, handling of soiled linen, and		
	CD TA //1				infection control. A post-test was		
		to assist RN #1 with the			administered to ensure		
		nence and bed change.			understanding of in-service		
	RN #1 and CNA	#1 were observed to don			provided.		
	gloves. RN #1 w	vashed the resident's left					
	buttock, placed to	he soiled cloth on the			What measures will be		
	over-the-bed tab	le, changed gloves, rinsed			put into place or what		
	the left buttock.	washed the mattress with			systemic changes will be		
	•	laced the soiled cloth on			made to ensure that the		
	_	table, then dried the			deficient practice does		
		tress and placed the			not recur		
		•			li	_	
		he bedspread at the foot			Licensed nurses and certified nursing	g	
		the changed gloves and			assistants have completed a skills validation. The DNS/Designee		
		the bed, then the staff			in-serviced all nursing staff that		
		nt to her right side and			included handwashing, perineal		
	CNA #1 remove	d the soiled pad and			care, handling of soiled linen, and		
	sheet, placed the	m in a plastic bag, and			infection control. A post-test was		
	made her side of	the bed. CNA #1			administered to ensure		
	changed gloves,	washed the right buttock,			understanding of in-service		
		the resident. Both staff			provided. Licensed nurses will utilize	:	
	•	RN #1 applied the cream			the nurse rounds checklist to		
		lent's front peri-area, and			monitor nursing staff on all shifts 7		
	_	the cream to the back			days a week x 2 weeks to ensure		
					appropriate infection control		
	•	#1 changed gloves, RN			practices are being performed.		
	_	on and put the soiled			DNS/Designee will monitor for compliance. Newly hired certified		
	_	with the other soiled			nursing assistants complete a		
		left the room with the			peri-care and hand washing skills		
	bag of soiled line	ens, and failed to wash			validation along with proper		
	her hands prior to	o leaving the resident's			infection control practices. The		
	room. RN #1 en	nptied, rinsed, and dried			validations and infection control		
		ashed her hands prior to			procedures are then completed no		
	leaving the resid	-			less than annually thereafter.		
	8 2						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155171			B. WIN	G		06/05/2012	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
55 A NUC					JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE	
	During the income was observed to on her groin area areas almost to he indicated during the resident had week-end which 2). Resident #D incontinence care a.m. with CNA #performing the chands prior to performing the chands prior to care. But CNA #2 washed wet cloth. The adry the resident's aides turned the and CNA #2 was buttock's area. If dropped to the fligown. The resident thoroughly clean with the same so placed a clean go gotten out of the soiled gloves and finish gloves and finish	and down both thigh and down both thigh and down both thigh and down both thigh are knees. RN #1 interview at this time, diarrhea over the caused it to be red. was observed for an one of one of			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed An Infection Control CQI monitoring tool will be completed once weekly 4, bi-weekly x 2, and then monthly thereafter until continued compliance is maintained for 2 consecutive quarters. The CQI committee will review the CQIs monthly. If at any time the threshold falls below 95% an action plan will be initiated.	x	
		NA #3 removed her aides washed their hands					
	-	ng the resident's room.					
	1 *	-	ı				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUI	LDING	NSTRUCTION 00	СОМР	E SURVEY LETED 5/2012	
		100171	B. WIN		DDDEGG CITY CTATE ZID CODI		7/2012
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST	1	
FRANKL	N MEADOWS				LIN, IN 46131		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	AD CAMBADA NA ANA CA CABBADA		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Review of the fa Perineal Care po which was the C sheet, indicated t "Procedure Steps explain procedur privacy. 3. Was gloves. 5. Assis position. 6. Dra Fill wash basin v resident check te resident to spread possible. 9. We cloth. 10. NOT catheter, check fi irritation. Gently meatus downwar inches. Do not r used wash cloth. cloth. Wet, soap Females: 12. Se urethral area firs outside labia in c Alternate from si front to back and outward. 15. Us wash cloth with rewipe area, unle the wash cloth. needed. Males: basin. With a cle area, thoroughly	cility's most recent licy dated 03/2012, NA Skills Validation					
	<i>3</i> .	515					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUILDING B. WING			COMPLETED 06/05/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	Assist resident to 23. Wet and soap anal area from from area of wash cloth not rewipe area, to of the wash cloth needed. 25. Chaw the a clean was thoroughly in the washing. 26. Goodirection was who resident to run or resident. 28. Reshands" Review of the fact Laundry/Linen who 2/2012, indicated laundry staff shall and transport line prevent the sprearesident-care area facility. PURPO proper care of line prevent the sprearesident line in place. The specific proper care of line prevent the sprearesided linen in place. Walidation check indicated, " 5 May giene: * Before the sprearesident which we would be the sprearesident which we will be the sprearesident which we would be the sprearesident which w	with reviewed date of ed, "POLICY: The landle, store, process, en appropriately to dof infection, in eas and in the laundry SE: To ensure the en and laundry to dof infection Place					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
7 IND I E7 IIV	155171		A. BUILDING B. WING	00	06/05/2012
	NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST (LIN, IN 46131	(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
	_	tient contact * After ient surroundings."			
	06/05/12 at 2:50 facility does not for peri-care that provided and ship provided was a check-off which detailed informathat they need to	he Administrator on p.m. indicated the have any other policies in what was already e realized what was tool for a training in did not contain the ation about pericare, and powork on that.			

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